Summary of the Meeting of the
Task Force on the Development of a Plan to Guide the
Future Mental Health Service Continuum

April 10, 2008

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Task Force Members Present:

Rex M. Cowdry, M.D., Chair	Maryland Health Care Commission
Lynn Albizo	National Alliance on Mental Illness - Maryland
Harry A. Brandt, M.D.	Maryland Psychiatric Society, Inc.
Laura Cain	Maryland Disability Law Center
Herbert S. Cromwell	Community Behavioral Health Association
Diane DePanfilis, PH.D., MSW	University of Maryland School of Social Work
Suzanne Harrison	Sinai Hospital of Baltimore – LifeBridge Health
David T. Jones, M.S.	Montgomery County Dept of Health and Human Services
Joseph Liberto, M.D.	VA Maryland Health Care System
Bonnie Katz	Sheppard Pratt Health System
Sako Maki, M.S.W., M.P.H.	Potomac Ridge Behavioral Health Services
Robert Murray	Health Services Cost Review Commission
Jill RachBeisel, M.D.	University of Maryland Medical System
Linda J. Raines	Mental Health Association of Maryland
Gayle Jordan-Randolph, M.D.	Mental Hygiene Administration
Mark A. Riddle, M.D.	The Johns Hopkins Hospital
Robert Rothstein, M.D.	American College of Emergency Physicians
Sally Tyler	AFSCME
Jane Walker	Maryland Coalition of Families for Children's Mental Health
Donna Wells, LCSW-C	Maryland Association of Core Service Agencies
Brenda Wilson	Maryland Insurance Administration

Commission Staff:
Pamela Barclay
Eileen Flack
Paul Parker

Mental Hygiene Administration Staff:
Daryl Plevy
Stacy Rudin
Keisha Tatum

Others Present:

Pat Cameron	MedStar Health
Howard H. Goldman, M.D., Ph.D.	University of Maryland, Baltimore
Kery Hummel	Maryland Psychiatric Society
Timothy Santoni, M.A.	University of Maryland, Baltimore
Sandra Sundeen, M.S., R.N.	University of Maryland, Baltimore
Linda Schools	University of Maryland, Baltimore

Pegeen Townsend Maryland Hospital Association
Pauline Layton

1. Call to Order

Rex Cowdry, M.D., Task Force Chair, called the meeting to order at 10:00 a.m., welcoming members of the Task Force and members of the public in attendance.

2. Introductory Remarks

Dr. Cowdry introduced the second White Paper on Roles of State and Private Hospitals in the Provision of Inpatient Psychiatric Treatment. He cited several aspects addressed in the paper, including a historical perspective, a review of statistics, an overview of the mental health funding system and questions related to inpatient mental health services, including options related to the relationships among funding, organization and results.

Ms. Barclay thanked Ms. Harrison for developing the taxonomy of mental health services that was e-mailed to the members and distributed at the meeting. She also indicated that Task Force materials are posted on the Commission website. Ms. Barclay noted that an updated White Paper, with full-sized copies of the maps, had been distributed to Task Force members as part of the meeting packet.

Dr. Cowdry conveyed Dr. Hepburn's apologies for not being able to attend the Task Force meeting because he is required to testify in a Medicaid fraud trial.

3. Approval of Previous Meeting Summary (Feburary 26, 2008)

The minutes of the February 26, 2008, meeting were adopted as presented.

4. Review and Discussion of White Paper: Roles of State and Private Hospitals in the Provision of Inpatient Psychiatric Treatment

Dr. Cowdry provided an overview of the White Paper, including: background and history, a review of the Maryland licensing system and the system for managing bed capacity, definitions of acute bed care, data about inpatient capacity and utilization, and payment policies and practices in the State. The White Paper includes information about four comparison states, a summary and presentation of policy options.

He referred the Task Force to Table 8 in the report, which compares the number of acute and forensic beds among acute general hospital, private psychiatric hospital and state hospital settings. Costs per patient per day in these settings are estimated to be $1000-$1300 in acute general hospitals, $700-$900 in private psychiatric hospitals and $500-$800 in state hospitals. Members were then directed to look at the maps in the report, which indicate the distribution of acute inpatient services and of hospitals that provide emergency psychiatric evaluation services. Several areas have access to emergency evaluations but not to inpatient psychiatric services in the same hospital (e.g., Garrett, Harford, Kent and Talbot Counties).

Referring to Table 7, Dr. Cowdry noted that 2008 Maryland data are being compared to 2000 US data. He suspects that Maryland continues to run slightly above the U.S. levels in rates of inpatient state and private psychiatric beds per 100,000 population. He noted a downward trend in private hospital beds and a stable state in acute general hospital beds. Each hospital type measures beds differently. State

hospitals use staffed beds, resulting in 98%-99% occupancy. In the private psychiatric hospital, beds are reported as licensed and do not consider patient census. Acute general hospitals use a formula that reflects 140% of the average daily census, which annually sets the licensed bed capacity at a level that assumes occupancy of 71%. Interestingly, the number of licensed beds in acute general hospitals corresponds reasonably well to the physical capacity of most units.

The Task Force's attention was drawn to Table 13 (Key Mental Health Service Policy and Payment Characteristics of Different Hospital Types). In particular they were asked to note the information on patterns of transfers of patients. Privately insured individuals who receive services in acute general or private psychiatric hospitals have their costs covered by the members of the insurance pool. For adults with Medicaid, acute general hospital costs are covered with funding coming from federal and state tax revenues. Medicaid does not cover the cost of private psychiatric hospitals, which are considered to be "Institutions for Mental Disease" (IMD) and excluded from Medicaid. In Maryland, the policy has been to pay for these hospitalizations with state tax revenue funding only. The IMD exclusion also applies to state hospitals and funding comes from state taxes. Uninsured individuals who go to acute general hospitals are figured into the hospital's uncompensated care mix and are paid for by all payers (Medicare/Medicaid and private insurance). Uninsured individuals in private psychiatric hospitals are paid for by State tax-funded purchase of care or these hospitals also have their own uncompensated care provisions. Costs for uninsured individuals in state hospitals are covered by state tax revenues.

Dr. Cowdry noted several factors that influence the shape of the mental health system. One is the tradition of the states being given primary responsibility for the inpatient treatment of mental illness as compared to their role related to physical illnesses. Commercial insurance, Medicare and Medicaid all have different policies related to reimbursement for mental illness. He also noted that Maryland had a waiver from the Medicaid IMD rule which was canceled in 2007. While it was in existence, the waiver allowed Medicaid reimbursement for admissions to private psychiatric hospitals. He discussed the relationship of the Certificate of Need process to the decrease in the huge jump in private psychiatric beds that occurred in the 1990's and the subsequent decline in these beds. Also the all payer rate setting system and the uncompensated care fund are unique to Maryland and have led to more stability in this State. He invited comments from Task Force members.

Dr. Brandt commented about the lack of referral of uninsured patients from one hospital to another. He related this to financial disincentives. Referral does happen but not often. He added that Mr. Murray will probably disagree, but most hospitals do not see it to their advantage to increase their uncompensated care. Dr. Cowdry added that professional staff are not compensated for uncompensated care. Dr. Liberto noted the omission of Veteran's Administration beds from the White Paper. There are 12 acute and 88 long term beds between the Baltimore and Perry Point sites. Dr. Cowdry thanked Dr. Liberto and requested the VA data for inclusion in future reports. Ms. Raines requested more data comparing psychiatric and somatic care beds. Ms. Walker noted the absence of bed numbers related specifically to children. Ms. Barclay agreed that there was a need for further data development.

- **Presentation: Overview of HSCRC Rate Setting System (Robert Murray)**

Mr. Murray emphasized that the rate setting system is a hybrid between establishing prices per unit of service related to costs plus DRG constraints. The unit rates cover price per unit. DRG's provide incentives for efficient utilization management. The HSCRC sets rates under the incentive system for 28 acute general hospitals with psychiatric units. There are three private psychiatric hospitals that have unit rates set but are not under the DRG system. Medicare will not reimburse for uncompensated care. Both Medicaid and Medicare rates are below those set for private sector payers.

The incentives built into the system are very similar to those established under the Medicare Prospective Payment System for acute hospitals and inpatient care. The principle policy reason for establishing the hybrid system was to align incentives across payers and influence hospitals to manage utilization. One aim was to structure a rate setting system compatible with that of managed care companies. The system also maintains payer equity and patient equity.

Unit rates are established based on detailed cost data provided by hospitals, including indirect costs and overhead. For the psychiatric rate center, there is the daily rate which is basically nursing care along with other costs such as contractual purchase of services and supplies, plus proportionate allocation of overhead for the entire hospital. Costs submitted to HSCRC are sorted into peer groups which are then averaged to set a standard. This is to set a standard, which is a reasonable standard, not a best practice standard. Costs are then layered into the various levels (direct, indirect, capital, other). The result is marked up. This mark-up is largely the uncompensated care provision which has been running 8%-9%. The actual mark-up is a little bit more than this because of other factors. The mark-up is uniform and stable. Maryland has had the lowest mark-up of hospital costs. We are at 18%-19% of costs to charges. Nationally, the average is over 170% and that just reflects cost-shifting related to Medicare and Medicaid payments. Charges nationally have no meaning relative to cost because they are arbitrary and depend upon what hospitals can do in manipulating their prices. The mark-up is uniform across all rate centers. This means that there is equal potential on a unit of service basis for profit or loss in psychiatric units versus any other service.

Dr. Brandt asked if there is a historical reason for the difference in rates set for acute general and private psychiatric hospitals. Mr. Murray responded that the initial negotiation for the waiver did not include private psychiatric hospitals. HSCRC does not have the ability to establish incentives for these hospitals. Dr. Cowdry asked about the 30%-40% higher costs in acute general hospitals as opposed to private psychiatric hospitals. Mr. Murray responded that the difference is most likely due to overhead costs. He added that uncompensated care in private psychiatric hospitals relates to care not reimbursed by private insurance. HSCRC does not cost shift Medicare and Medicaid shortfalls.

Mr. Murray elaborated on the issue of uncompensated care. HSCRC has established methodologies to account for predicted levels of uncompensated care by facility. They use a regression methodology based on various data elements that have been highly correlated with uncompensated care over time. This will predict an amount for each hospital. It is also blended with a three-year moving average of actual costs. There is a lag because the rate is based on historical data. For years in which uncompensated care decreases, uncompensated care is overfunded. If uncompensated care goes up in a given year, the rate lags behind. Over time, uncompensated care is 98%-99% reimbursed. This is related to the whole hospital not just psychiatry. Mr. Murray stated that it is not appropriate to tag uncompensated care to psychiatry. Hospital financial officers may look at the rate and say that psychiatry generates higher levels of uncompensated care than other services and that this could cause them to have to eat the costs if they go over the amount for the year. This needs to be balanced against opportunity costs of fully insured private pay patients. The hospital's assertions may be true but represent a very short-term narrowly focused look.

While he appreciated Mr. Murray's explanation, Dr. Brandt observed that in his experience hospitals do tend to look at uncompensated care by cost center. Mr. Murray also offered to meet with hospital CEO's/CFO's. He emphasized the social mission of hospitals. Ms. Katz clarified that the uncompensated care factor covers what might be called "charity care". Mr. Murray agreed. She also asked about UR beds and denied days. Mr. Murray said that these are medical necessity issues. Ms. Katz asserted that the situation may not always be clear cut in psychiatry. For instance, a person may come in classified as insured but really be under-insured and denied payment for part of the episode of care. In that instance, the hospital would have been better off if the person had been admitted as uninsured. Dr.

Cowdry raised the issue of social desirability of psychiatric services and if this might influence hospital attitudes. He asked if the rate-setting system should take such factors into account. Mr. Murray acknowledged that undesirability is probably not included in the cost-setting. Dr. Riddle asked about additional costs incurred by academic teaching hospitals. Mr. Murray explained that costs for teaching are built into the rates for academic medical centers. If they were to close their psychiatric services, their teaching provision would be negatively impacted.

Mr. Murray proceeded to a discussion of the DRG system. HSCRC now uses a severity adjusted DRG that collapses most of the DRGs from 550-600 to 350, but then breaks out each one into four severity categories. Statistically and operationally this does a better job of explaining resource variation associated with severity except for the psych DRGs. This is probably because there has not been much attention paid to the psych categories. Also the ICD-9 classification system for psych diagnoses is not very robust. The DRG assignment is based on documentation in the medical record. He pointed out the bimodal distribution of hospital costs for psychiatric services based on DRGs. Because of the problems with the psych DRGs it is possible to have a particularly difficult patient who is not picked up by the codes and underlying data as the system exists now and costs are inadequately reimbursed. However, other data on other patients may lead to overpayment. In the past, if the Commission noted that there was a pattern of underpayment, adjustments were made. HSCRC is working with the Johns Hopkins University Bloomberg School of Public Health to develop algorithms that would assist in refining the psych DRGs. He then invited questions from Task Force members.

Ms. Albizo asked if the HSCRC is tracking readmissions. Mr. Murray replied that this is not happening now but will be in the next year. They also plan to look at patient movement between acute general and private psychiatric hospitals. In response to a question from Ms. Cain, Mr. Murray stated that it is difficult to compare hospital lengths of stay related to efficiency because inadequate DRGs make it impossible to determine the appropriate level of service. Dr. Brandt observed that more variability associated with less specific DRGs could result in a hospital taking greater risks with psychiatric patients. Mr. Murray agreed that that could be a consequence. Ms. Harrison raised the issue of using a different category for academic teaching hospitals when there are patients who are high utilizers of service and tend to bounce from hospital to hospital, including teaching, acute general and private hospitals. Mr. Murray referred to a series of discussions several years ago that resulted in the differentiation which was based on higher lengths of stay in the teaching hospitals. She also asked about the inclusion of medical dual diagnosis as a factor. Mr. Murray responded that the current system does not include that. Ms. Harrison went on to inquire about other dual diagnoses, such as mental health/substance abuse or mental health/developmental disability. Mr. Murray agreed that those factors should be taken into consideration. He noted that the ability to address these issues at the State level is a strength of Maryland's rate setting system.

Ms. Katz addressed the issue of patients who have extended stays in emergency departments and may not ever be admitted. She wanted to know about billing and compensation for services provided to that group. Mr. Murray responded if the person was uninsured it would be part of the hospital's uncompensated care mix. Ms. Katz asked the members if anyone knew about how hospitals bill for compensated care for psychiatric emergency room stays. Dr. Riddle replied his understanding is that the billing is based on a level system. Ms. Sako requested more information about compensation for the actual cost of care for a psychiatric patient in the emergency department. Mr. Murray said that it is picked up on average by being built into the DRG weight or on the outpatient side, fee-for-service. He emphasized that the rate setting system is based on averages and on costs over time.

Mr. Cromwell asked for elaboration on the similarities or differences between psychiatric and other hospital services. For instance, are there greater opportunities in other areas of medicine for hospitals to make more money? Are there incentives for hospitals to move toward other services? Mr.

Murray responded that it depends on the hospital's long-term experience and how that is interpreted by the CEO and CFO. Dr. Cowdry observed from the behavioral economist's perspective that there is some reason that unlike other services, there is no one in line to open a new psychiatric unit. Mr. Murray addressed the "halo effect" of having some types of services in that they tend to draw in additional volume for other services. HSCRC has tried to deal with this by instituting an 85% variable cost arrangement in the rate setting to create a lower incentive to generated volumes across the board related to the halo effect. They have also corrected for a higher DRG rate that was applied in the past. Medicare is making a similar correction. Higher that appropriate DRG's result in an incentive to provide more of the related services. Ms. Raines observed that the hospitals that contribute to the high end of the average cost will continue to fail to meet their costs and will have a negative view about the patient group that causes their costs to be above average. Mr. Murray agreed but emphasized that there needs to be a long-term view of costs. He hopes that the DRG initiative will help with this problem.

Dr. Goldman commented that, based on his experiences with Medicare, the all payer system is a better way of setting hospital payments. Since there has been such a good job of calibrating the relationship between revenue and real costs, Dr. Goldman noted that the opportunities to make money are limited. The opportunity to be a "big winner" is greater outside of an all payer system. He pointed out that in the psychiatric system there appear to be small ways in which hospitals are losing, i.e., if the DRG's get rectangular distributions and you have more than your share of those, these are key trim points and you are going to lose. He went on to say, if you are losing 2 cents on the dollar as uncompensated care that is outside of the all payer system, on a larger volume of patients it is a great deal. Hospital administrators look at the very small perceived losses and add them up. One approach that has been taken is to look at the trim points and make adjustments. He suggested that the Task Force could consider recommending a series of small adjustments that would overcome the disincentives that are perceived by hospital administrators. Mr. Murray indicated that the HSCRC is always open to refinements in the system as long as they are empirically based. He added that the part of the perception that is an irrational response needs to be cleared away first. He also pointed out that the opportunities for both gain and loss are limited in the Maryland system. This is reflected in the fact that the variation in our margins and profitability is much narrower than it is in the rest of the nation which is roughly +/- 20%. Here it is much narrower. From a policy perspective, where a stable financial situation is desirable, Maryland's situation is much better. However, we do need to get the incentives right, but maintain a reasonable range. Adjustments should be empirically based and data-driven as the HSCRC is planning to do with the DRG refinement.

Dr. Cowdry introduced a discussion of the second White Paper. He noted that Pennsylvania and Massachusetts have both moved most of their acute care out of the state hospital system. He noted that it has been the position of the Mental Hygiene Administration that this is a desirable direction in which to move. However, the paper points out the many challenges to making that move. The other comparison of note is per capita funding among the states. Maryland actually spends a great deal in comparison to others and a substantial part of that has moved to support community services. Yet, there are the continuing issues about emergency department stays and hospital admissions.

He identified the focus for this meeting as the issues involved in the organization and delivery of acute psychiatric care. The paper lays out a series of options as a starting point for discussion. He summarized the options as follows:

Option 1A: All acute inpatient care should be provided in psychiatric units of general hospitals.

Acute admissions would go to acute psychiatric units of general hospitals if the capacity could be built. Finding the right incentives is challenging. It would mean that all Medicaid eligible people are funded by Medicaid. Maryland is moving to expand Medicaid coverage limits from one of the lowest in the nation to one that is at least defensible because of recent actions by the Governor and legislature. Adult eligibility has been moved up to 116% of the federal poverty level.

Option 1B: All acute inpatient care should be provided either in psychiatric units of general hospitals or in private psychiatric hospitals.

This is a hybrid option which encourages use of psychiatric units in general hospitals especially for Medicaid eligibles allowing access to the federal match.

Option 1C: All acute inpatient care should be provided either in psychiatric units of general hospitals or in private psychiatric hospitals, but funding of uncompensated care in both settings would be through Purchase of Care beds.

An alternative would be to use private psychiatric hospitals that are funded either through purchase of care or through the private psychiatric hospital uncompensated care provisions which are challenging because of the limited base of payers contributing to the fund. Dr. Cowdry added that this option is included so the list of options is complete but is not really one that will attract much support because of the reliance on using state general funds.

Dr. Cowdry summed up Option 1 A-C by raising the following questions:

- Do we change our concept of how we use the different components of the system?
- What are the problems with doing that from the perspectives of the patient and the hospitals?
- How would we pay for it?
- What would the financial implications be?

Option 2: Generate increased inpatient capacity in acute general hospitals through rate increases.

This option would change the incentives to increase capacity.

Option 3: Restrict emergency receiving facilities to acute general hospitals with psychiatric units.

This would leave people in far Western Maryland with a long drive to an evaluation site.

Option 4: Maximize Federal financial participation.

This would require admitting Medicaid eligible adults only to general hospital units.

Option 5: Under a new federal administration, Maryland would seek reinstatement of the previous IMD waiver.

When the administration changes in January, Maryland should go back and say that the waiver worked; it was able to provide care in a somewhat less expensive setting.

Option 6: Include private psychiatric facilities in the uncompensated care fund but not in the Medicaid waiver test.

It would be difficult to accomplish both of the elements of the option. There would be risk in opening up the waiver that the state has opposed in the past.

Dr. Cowdry asked the Task Force for comments and questions about the options. Ms. Katz asked for clarification of the problem that the options are designed to solve. Dr. Cowdry related it to the issues of people in emergency department who cannot be admitted because of funding constraints such as lack of funding for private psychiatric hospitals without using purchase of care state funds. It also related to the major policy issue: What do we do with the 200-300 acute beds in state hospitals. Related questions include: What is the quality of care in state hospitals? Do the outcomes of state hospital care match outcomes in other settings? How does the cost of a stay in a state hospital compare with other settings? It appears to be a bit higher than that of acute general hospitals. We don't have data about quality issues from the patient's perspective. Cost issues have not yet been fully analyzed. The Task Force needs to address what best serves the system as a whole.

Dr. Goldman identified the task as determining the right number of inpatient beds related to relieving pressure on the emergency department. Then there is a need to describe the system of care and the functions it performs. For acute care, in the current system where you go is determined by clinical needs as well as ability to pay. This differs from the general medical system where there is not the option of a public hospital. Ms. Katz responded that the role of the state facilities should be determined before further consideration of the funding options. Ms. Maki requested clarification of whether the discussion of the role of state facility beds was only for acute services or is there consideration of complete elimination of state beds. She is in support of giving individuals the choice of receiving initial treatment in a community hospital but believes that there will still be a role for state-funded beds. Ms. Harrison added that providers perceive that there is a shortage of bed capacity and she does not believe that the reasons for that have been identified. She questioned whether the Task Force is looking for a temporary solution while other service types are made available or for a permanent solution. She stated her opinion that the current situation is not permanent so the problem for the Task Force needs to be defined.

Dr. Rothstein raised concerns about current system capacity to maintain patients in emergency departments and the impact of psychiatric patients who cannot be discharged. He added that this White Paper does not discuss community alternatives to prevent admissions and this is an essential part of the solution. Dr. Cowdry agreed and noted that a White Paper focusing on best practices to divert patients from emergency departments and inpatient hospital care was being prepared for presentation at the next Task Force meeting. However, this paper is focused on the need for inpatient capacity. Mr. Cromwell observed that more than 20 years ago DHMH recommended the need for additional community-based hospital diversion services.

Dr. Riddle stated his belief that the fewer people in the state hospital the better because of the associated stigma. He urged the development of a clear definition of "acute" to prevent the clogging up of beds with individuals who really require intermediate care. The revision of the DRG's would also be a key element in this. Ms. Cain supported the need to define "acute". The options relate acuity to payment but there are other issues that complicate and could extend the length of stay. Pennsylvania does not provide public hospital acute care. Perhaps we could get more information from them about their definition of acute care and the related length of stay along with the disposition for people who need longer stays. She stated that MDLC supports the development of community supports to avoid the need for hospital admission. She reinforced the stigmatizing nature of state hospitalization for acute care and stated her belief that resources devoted to state hospitals could be utilized better to support community services. Ms. Harrison added that the Task Force also needs to address the issue of patients who receive

emergency evaluations at hospitals that do not have inpatient psychiatric units and cannot be transferred to hospitals with inpatient units resulting in a state hospitalization. Mr. Murray agreed that the Task Force should look at community services before making recommendations about hospital acute care bed needs. Dr. Brandt added that it would be important to project the impact of having the state hospital acute population added to the current acute population, especially given the problem with the usefulness of the current DRG's. Dr. Cowdry stated that the state hospital acute population has not been characterized adequately. He also placed the issue of transferring acute care to the community in the context of a long-term goal that could guide planning over time. However, the question of the purpose of state hospitals must be addressed.

Ms. Harrison inquired about whether it is possible to get data identifying patients who enter the mental health system multiple times with multiple providers. Ms. Rudin replied that that would be possible. Dr. Jordan-Randolph added the Administrative Services Organization has initiated a high utilization program that creates early intervention at contact with the emergency department and providers and tries to coordinate care with a consistent plan including aftercare and follow-up. Ms. Harrison asked for clarification of what data is available. Ms. Rudin stated that statewide Medicaid purchase-of-care data and state hospital data should be accessible. Dr. Cowdry reported that he had talked with Dr. Hepburn about identifying the difference between acute patients who spend 22-30 days in state hospitals and those who spend 7 days in acute general hospitals. Dr. Hepburn does not believe there is a difference but it would be helpful to have data about that. Dr. Jordan-Randolph stated that it has been observed that the patients who receive purchase-of-care funded services in acute general hospitals have 7-8 day lengths of stay. She elaborated on some of the advantages available in the private sector related to lower cost of care and access to technological support. Ms. Rogan raised the issue of the need to also look at the result of the episode of care and the relationship, if any of that, to length of stay. Dr. Jordan-Randolph responded that the state hospitals do collect readmission data, but it can be difficult to interpret because of lack of information about the patient's experience while in the community. She went on to address the complexity of the causes of emergency room backups and the need to work in terms of developing multiple strategy recommendations.

Dr. Jordan-Randolph noted that individuals who come to emergency departments frequently have multiple problems and diagnoses, including medical, developmental disability, and substance abuse in addition to mental health. She added that there is a need to look at the changing role of the emergency department. She also addressed the need to consider the impending closure of the Rosewood Center and the potential impact of that on the mental health system. She stated her belief that the standard of evaluation in the emergency department has a great influence on the process of care. In terms of transfers of patients from emergency departments to other hospitals, she noted that patients can accept or reject transfers. The Task Force should comment on that process. She also mentioned that DHMH has a number of diversion program pilots that are designed to alleviate pressure on emergency departments. Dr. Riddle questioned the similarity of acute patients in state hospitals and community hospitals. Dr. Jordan-Randolph replied that the adolescent unit at Spring Grove Hospital Center is now predominantly forensic and, therefore, different. Ms. Katz refocused the discussion to the issue of needing to define acute care including consideration of patients who have forensic involvement.

Ms. Rogan expressed her shock at finding out how few child and adolescent beds are available in the system. Ms. Maki wondered if community hospitals are able to reject purchase-of-care patients because they do not believe that they have the capacity to manage the acuity level of the patient and those patients are referred to state hospitals. Dr. Jordan-Randolph stated that there are very few acute admissions in state hospitals at the present time. What exists is mostly in the more rural parts of the state, but there are few in the central region. She said most acute patients are hospitalized using purchase-of-care and the current state hospital admissions tend to be forensic patients. Some of the acute patients have forensic involvement.

Ms. Katz offered that Sheppard Pratt has developed a number of subspecialty units to address the needs of some of the populations that have been backing up in emergency departments. They have also tripled their outpatient capacity in the last few years. Most recently, Sheppard Pratt has opened a unit for adults with developmental disabilities.

Dr. Brandt asked for clarification of Dr. Jordan-Randolph's description of the state hospital population since it sounded like the issue before the Task Force had already been addressed. Dr. Jordan-Randolph responded that the state hospital population is mostly forensic and long-term. She added that the acute care referrals are being picked up by purchase-of-care. Ms. Rudin added that there is a need to look at the point in time at which acute care patients in community hospitals should be transferred to state hospitals. Dr. Cowdry presented the need to understand the numbers that the Mental Hygiene Administration presented regarding acute care beds. The Task Force needs more data. The question that needs to be addressed is: Is there a need that is currently being met by the state hospital system that should be met instead by either private psychiatric hospitals or acute general hospitals? Ms. Rudin responded that the State can provide data on forensic vs. non-forensic admissions and related lengths of stay. Dr. Cowdry agreed that this data would be helpful.

Ms. Rogan asked how many of the people going to purchase-of-care beds could be covered by uncompensated care. Dr. Cowdry responded that all of them could be. Mr. Jones reintroduced the issue of community resources needed to prevent admissions. Ms. Barclay responded that this will be the topic of the next White Paper. It will discuss best practices to divert people from hospital or emergency department admissions. Ms. Harrison added that prolonged hospital stays are often related to lack of referral resources in the community. This limits the hospitals ability to control costs by limiting length of stay.

Ms. Katz raised the issue of the unintended consequences related to the voluntary relinquishment of custody provision related to services to children and adolescents. She related this to inadequate commercial insurance coverage which forces parents to relinquish custody of a child so the child can qualify for Medicaid and receive needed services. This places an extreme burden on local Departments of Social Services who become the custodians. Because of this there is a period of time that elapses before custody is assumed and treating facilities have children for whom they have no permission to treat and no ability to discharge.

Dr. Riddle reintroduced the need to define acute vs. intermediate lengths of stay. Dr. Goldman referred to the White Paper which states that state hospitals would be paid for intermediate, forensic and long term care. He raised the concern that acute hospitals would be inclined to transfer patients to intermediate beds as soon as they became financial losers. The purchase-of-care length of stay data shows that acute care stays are about a day longer on average than other acute admissions. This would indicate that a very small number of people would require a transfer to a state hospital. It will be important to document length of stay and diagnoses. There could be a residual function for acute care in state hospitals. Dr. RachBeisel advocated for reviewing the definition describing the continuum of care. Dr. Goldman responded that the planning process will focus on improving emergency department ability to access the system, the role of the acute hospital and enhancing community-based services.

Dr. Jordan-Randolph offered a clarification of her earlier comments. She stated that the forensic beds identified in Table 8 of the White Paper are at Clifton T. Perkins Hospital Center. However, the regional hospitals also treat forensic patients. Civil and forensic cases are mixed in the 391 acute beds. The State would like to move away from acute care because the average length of stay for acute care is 22-29 days. The state would then focus on monitoring responses to treatment, adjusting it as needed and coordinating with community programs. Dr. Cowdry requested further breakdown of the 391 beds related

to forensic vs. acute care, as well as any other data that would assist the Task Force to understand the utilization of those beds.

Dr. Rothstein inquired about whether the state has any utilization review data about factors that contribute to the 22 day length of stay in acute beds, especially related to resources. There are two ways to change the length of stay for those patients: Provide more resources to the state facilities or admit the patients to places where the resources are available. This would also involve a more in-depth analysis of the characteristics of the patients to see if they really are comparable. Dr. Brandt expressed concern about financial resources for providing acute care in the community disappearing in the future. He advocated for a long-term plan that would account for these concerns.

Ms. Katz commented that another reason for difficulty discharging patients from emergency rooms is availability of third party payers overnight for authorization of services. The best availability is offered by Maryland Medicaid. Also, some hospitals do not provide psychiatric staffing in the emergency room 24 hours a day. She emphasized the difficulties related to the inadequacies of commercial insurance plans and their reluctance to pay for psychiatric services. Ms. Katz also introduced the need for true parity of mental health reimbursement at all levels including Medicare and commercial payers. Dr. Cowdry reminded the Task Force that the all payer system resulted from negotiations with the federal government which was very concerned about the huge cost of assuming fiscal responsibility for the state hospital system. The IMD waiver was included to protect them from this risk. At this point, the question is: Is there a way either to change the system, which will be hard, or to find that we can rely on a more reliable source of funding than appropriations, i.e., the all payer system. There are still dozens of issues to be discussed.

Ms. Albizo requested a schedule of production of future White Papers and the associated topics. Ms. Barclay reviewed the plan which was to start with a framing paper, then address roles, then best practices and then quality measures and data gaps. There could be another topic that the Task Force will want to address. We need to remember that we need to work with a compressed period of time. She said that future meeting dates to discuss the White Papers that are in process will be sent to members next week. The goal is to have a draft report by September.

Mr. Cromwell suggested inviting representatives of pilot diversion programs to the next meeting and asking them to present what they are doing. Ms. Barclay asked him to send suggestions and contact information for possible presenters.

5. Adjournment:

The meeting adjourned at 4:00 p.m.

Next Meeting: May 27, 2008
1:00-4:00 p.m.
Maryland Health Care Commission